10/2016

Application for Exemption from the Shared Responsibility Payment for Individuals who are Unable to Afford Coverage and are in Certain States with a State-based Marketplace

Form Approved
OMB No. 0938-1190

Use this application to apply for an exemption from the shared responsibility payment

- Every person needs to have health coverage or make a payment on his or her federal income tax return. This is called the "shared responsibility payment."
- Some people are exempt from making this payment. This application includes one category of exemption. There are other applications for other categories of exemptions. You may apply for certain categories of exemptions when you file your federal income tax return.
- You don't need to apply for an exemption if you're not going to file a federal income tax return. If you're not sure you'll file a tax return, you may want to apply for an exemption anyway.

Who can use this application?

- **Use this application if you're unable to afford coverage. If you get this exemption, you may be able to buy catastrophic coverage.**
- **Use this application if your state has its own Marketplace. Visit HealthCare.gov, or call 1-800-318-2596 to see if your state has its own Marketplace. TTY users should call 1-855-889-4325.**
- You can use one single application to ask for this exemption for more than one person in your tax household.

When can you get this exemption?

Use this application to ask for an exemption for months **in the future**. If you want this exemption for a whole calendar year, you need to request it before the year starts. **You can't get this exemption for time in the past**. If it's after December 31 of the year you need the exemption for, you can apply for this exemption on your tax return instead.

What you may need to apply

- Social Security Numbers (SSNs), if you have them.
- Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements).
- Information about any job-related health coverage available to your family.
- Proof of your expected yearly income for the year you need this exemption for. See page 5 for examples of documents you can send.

Why do we ask for this information?

We ask for Social Security Numbers and other information to make sure your exemption is counted when you file your federal income tax return. **We'll keep all the information you give private and secure, as required by law.** To view the Privacy Act Statement, go to HealthCare.gov or see instructions.

Get help with this application

- **Online:** HealthCare.gov.
- **Phone:** Call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.
- **In person:** There may be counselors in your area who can help. Visit HealthCare.gov, or call the Marketplace Call Center at **1-800-318-2596** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-800-318-2596.**
- **Other languages:** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this product in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit **www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html**, or call the Marketplace Call Center at **1-800-318-2596** for more information. TTY users should call **1-855-889-4325**.

Please print in capital letters using black or dark blue ink only. Fill in the circles (◯) like this →●.

STEP 1: Tell us about yourself.

(The person who files a federal income tax return in your household should be the contact person for this application. If you're applying for an exemption for a child, we need an adult who claims the child on his or her federal income tax return to fill out this information even if the adult doesn't need the exemption.)

Do you live in California, Colorado, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, or Washington?

◯ **YES.** Fill out this application.

◯ **NO.** Visit **HealthCare.gov/exemptions**, or call **1-800-318-2596** to find out how to apply for this exemption.

Give your legal name

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County, parish, or township

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County, parish, or township

14. Daytime phone number	15. Evening phone number

Please give us a phone number so the Marketplace can contact you if we need more information to process your application. We won't use your phone number for any other purpose.

16. Do you want to get information by email from the Marketplace? ..... ◯ Yes ◯ No

Email address:

17. What's your preferred spoken language? What's your preferred written language?

STEP 2: Tell us about your tax household.

Who do you need to include on this application?

You need to complete Step 2 for every person in your household who is on the same federal income tax return.

For Person 1:

Person 1 must be an adult who files a federal income tax return in your household, even if they don't want an exemption.

For Person 2:

Person 2 can be either:

- A spouse who files taxes jointly with Person 1.
- Anyone that Person 1 claims as a dependent on the same tax return.

Who not to include:

- A spouse who files taxes separately. Spouses who file separately need to fill out a separate application for themselves and for each person they claim on their tax return.
- Anyone who lives with you but who isn't listed on your tax return. Each person who needs an exemption must be on an application with the person who lists them on a tax return.

If you don't plan to file taxes, you don't need to apply for an exemption.

You'll get an eligibility determination letter in the mail after your application is processed. If you get this exemption, we'll give you an Exemption Certificate Number (ECN) with your approval letter. **Keep the letter for your records.** You'll need to put this number on your federal income tax return at the time you file taxes.

We'll keep all the information you provide private and secure, as required by law. We'll use personal information only to check if you're eligible for an exemption.

STEP 2: PERSON 1 (Start with yourself.)

Person 1 must be the person who files a federal income tax return, even if the person doesn't need this exemption.

1. First name	Middle name	Last name	Suffix

2. Relationship to you?	3. Date of birth (mm/dd/yyyy)	4. Sex
SELF	/ /	◯ Male ◯ Female

5. Social Security Number (SSN) ___ - ___ - ____

If you're requesting an exemption for yourself and you have an SSN, you must provide it. You aren't required to have an SSN to get this exemption. If you're not requesting an exemption for yourself, providing your SSN can be helpful because it can speed up the application process. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Do you plan to file a federal income tax return?** ◯ Yes ◯ No
   a. Will you file jointly with a spouse? ◯ Yes ◯ No
      If yes, write name of spouse:
   b. Will you claim any dependents on your tax return? ◯ Yes ◯ No
      If yes, list name(s) of dependents:

7. Do you want this exemption? ◯ **YES.** ◯ **NO.**

8. **Yearly Income:** We need to know about any income you made or expect to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and taxable amount of Social Security benefits (see Internal Revenue Service (IRS) Form 1040 line 20b or IRS Publication 915). The income you list below should be the same income amount you put on your health coverage application for your state's Marketplace, EXCEPT you should subtract any Social Security benefit amounts that are **not taxable**. You also need to submit at least one support document for each type of income you include in your estimate.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

9. If your employer withholds some of your wages and uses them to pay for health coverage, list the amount that is withheld each year:
$

10. **Are you offered health coverage from a job?**
Select yes even if the coverage is from someone else's job, such as a parent or spouse.
◯ **YES. If yes,** you'll need to complete and include Appendix A.
◯ **NO.**

Optional: *(Fill in all that apply.)*

11. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

12. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

STEP 2: PERSON 2

Make a copy of this page if there are more than 2 people in your household.

Fill out this page for a spouse who files taxes jointly with you and for anyone you claim as a dependent on your federal income tax return.

1. First name | Middle name | Last name | Suffix

2. Relationship to PERSON 1?

3. Date of birth (mm/dd/yyyy) ___/___/_____

4. Sex ◯ Male ◯ Female

5. Social Security Number (SSN) ___-___-_____

If PERSON 2 is requesting an exemption and has an SSN, he or she must provide it. PERSON 2 isn't required to have an SSN to get this exemption. We use SSNs to help make sure that if you get an exemption, it's applied correctly on your taxes. If someone wants help getting an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users should call **1-800-325-0778**.

6. **Does PERSON 2 plan to file a federal income tax return?** ◯ Yes ◯ No
   If yes, answer 6a and 6b. **If no**, go to question 7.
   a. Will PERSON 2 file jointly with a spouse? ◯ Yes ◯ No
      If yes, write name of spouse:
   b. Will PERSON 2 claim any dependents on his/her tax return? ◯ Yes ◯ No
      If yes, list name(s) of dependents:

7. **Will PERSON 2 be claimed as a dependent on PERSON 1's tax return?** ◯ Yes ◯ No
   If yes, please list the name of the tax filer:
   How is PERSON 2 related to the tax filer?
   Note: If PERSON 2 isn't listed on PERSON 1's tax return as a spouse or as a dependent, PERSON 2 must file a separate application.

8. Does PERSON 2 want this exemption? ◯ **YES.** ◯ **NO.**

9. **Yearly Income:** We need to know about any income PERSON 2 made or expects to make from a job, self-employment, unemployment, retirement, pensions, rental property, fishing/farming, alimony, and the taxable amount of Social Security benefits (see Internal Revenue Service (IRS) Form 1040 line 20b or IRS Publication 915). The income you list for PERSON 2 below should be the same income amount you put for PERSON 2 on your health coverage application for your state's Marketplace, EXCEPT you should subtract any of PERSON 2's Social Security benefit amounts that are **not taxable**. PERSON 2 also needs to submit at least one support document for each type of income he/she includes in his/her estimate.

PERSON 2's total income **this year**
$

PERSON 2's total income **next** year (if you think it will be different)
$

10. If PERSON 2's employer withholds some of PERSON 2's wages and uses them to pay for health coverage, list the amount that is withheld each year:
$

11. **Is PERSON 2 offered health coverage from a job?**
Select yes even if the coverage is from someone else's job, such as a parent or spouse.
◯ **YES. If yes,** you'll need to complete and include Appendix A.
◯ **NO.**

Optional: *(Fill in all that apply.)*

12. **If Hispanic/Latino, ethnicity:** ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban ◯ Other _____

13. **Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Filipino ◯ Japanese ◯ Korean ◯ Asian Indian ◯ Chinese ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian or Chamorro ◯ Samoan ◯ Other Pacific Islander ◯ Other _____

Thanks! This is all we need to know about PERSON 2.

STEP 3: Lowest cost Marketplace plan

Unless you're offered health coverage from a job, you must submit this application with 2 pieces of information that are only available through your state's Marketplace.

If you aren't offered health coverage through a job, you need to submit an application for health coverage to your state's Marketplace, complete the process, and send us **2 things**:

1. **A copy of the eligibility notice from your application to your state's Marketplace. The notice needs to show the maximum premium tax credit you qualify for (if you qualify for any).**
2. **Information from your state Marketplace's web page that lists the health coverage plans available for you to buy. Print and mail us a screen shot that shows the monthly premium amount of the lowest-cost bronze level plan you can buy. Include the plan that's available to everyone who wants this exemption.**

Note: If there isn't a single bronze plan that covers everyone in your tax household who is requesting an exemption, send us the screens showing the lowest-cost bronze plans that add together to have the lowest cost for everyone.

Important: We can't process your application without this information. If you need help locating this information, you can visit your state's Marketplace website or call them at the number listed below:

State	Website	Phone number
California	coveredca.com	1-800-300-1506
Colorado	connectforhealthco.com	1-855-PLANS-4-YOU (1-855-752-6749)
District of Columbia	dchealthlink.com	1-855-532-5465
Idaho	yourhealthidaho.org	1-855-YH-Idaho (1-855-944-3246)
Maryland	marylandhealthconnection.gov	1-855-642-8572
Massachusetts	mahealthconnector.org	1-877-MA-ENROLL (1-877-623-6765)
Minnesota	mnsure.org	1-855-366-7873
New York	nystateofhealth.ny.gov	1-855-355-5777
Rhode Island	healthsourceri.com	1-855-840-HSRI (1-855-840-4774)
Vermont	healthconnect.vermont.gov	1-855-899-9600
Washington	wahealthplanfinder.org	1-855-WAFINDER (1-855-923-4633)

STEP 4: Proof of yearly income

You MUST submit proof of each type of income you listed for each person on this application. We can't approve your exemption without proof of income. The table below lists possible documents for each type of income; you may submit other documents not on the list if they show the income amount you listed on your application.

If you expect your income to go up or down during the year you are requesting this exemption, you can provide other documents, like a document that states when contract work will end. If any of your income comes from freelance work, you can fill out a self-employment ledger that includes your expected income.

Income Type	Documents
All income types	• A copy of your most recent federal income tax return, Form 1040, if your income and/or deductions listed on this application is similar to your last tax return. Send official documents only — handwritten 1099s and W-2s are not acceptable.
Job	• One or more pay stubs that show the typical pay and hours you work at the job. The pay stubs should show the gross amount and any tips, commissions, bonuses, or overtime pay. • Wages and tax statement (W-2) from the most recent year • 1099-MISC (Non-employee compensation)
Net self-employment	• Self-employment ledger • Schedule C • Form 1120S • Other recent tax document showing self-employment • Copy of a check paid for the self-employment services
Other income	**Documents**
Unemployment	• Letter from government agency for unemployment benefits. If the document doesn't list the start and end dates, write your best guess at when the benefit will end on the document.
Retirement (taxable amounts ONLY)	• 1099 or relevant tax document that list any withdrawal amounts • Documents showing taxable amount from account withdrawals
Pension	• Pension letter • 1099 or relevant tax document
Rental/royalties (net)	• Lease agreement for land or property you own with lease amount/frequency • Document showing royalty income • 1099-MISC (royalty/rental income fields)
Alimony paid/received	• Court order or legal document showing the monthly alimony amount and the start and end dates (if applicable)
Farming/fishing (net)	• Schedule C • Schedule F • 1099-G
Social Security (taxable amounts ONLY)	• Copy of most recent Form 1040 that shows the taxable amount in line 20b. Don't send copies of your benefit or COLA letter UNLESS the taxable amount is listed on it.

STEP 5: Read & sign this application

- I'm signing this application under penalty of perjury, which means I've given true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I give false and/or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.

Is anyone applying for an exemption on this application incarcerated (detained or jailed)? ◯ Yes ◯ No

If yes, tell us the person's name. The name of the incarcerated person is:

◯ Fill in here if this person is facing disposition of charges.

We need this information to check your eligibility for an exemption if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

What should I do if I think the results of my exemption application are wrong?

If you don't agree with the results of your exemption application, you can ask for an appeal. Below is important information to consider when requesting an appeal:

- The Health Insurance Marketplace must receive your appeal request within 90 days of the date of the notice of the application results.
- You may have a relative, friend, legal counsel, or another spokesperson, including an Authorized Representative, help you make an appeal request or participate in your appeal. This is optional.
- The outcome of an appeal could change the eligibility of other members of your tax household.

To appeal your exemption application results, visit **HealthCare.gov/marketplace-appeals/**. Or call the Marketplace Call Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

PERSON 1 should sign this application. If you're an authorized representative, you may sign here as long as PERSON 1 signed Appendix C. The person who signs this application must be the person who files a federal income tax return and is an adult over the age of 18.

Signature	Date signed (mm/dd/yyyy)
	/ /

STEP 6: Mail completed application

Mail your signed application and documents showing your yearly income (see examples on page 5) to:

Health Insurance Marketplace – Exemption Processing
465 Industrial Blvd.
London, KY 40741

What happens next?

Send your complete, signed application with required documents to the address above. We'll follow up with you within 1–2 weeks. You may receive a call from the Marketplace if we need more information. You'll get an eligibility determination letter in the mail after we process your exemption application. If you qualify for this exemption, we'll give you an Exemption Certificate Number (ECN) that you'll put on your federal income tax return. If you don't hear from us, call the Health Insurance Marketplace Help Center at **1-800-318-2596**. TTY users should call **1-855-889-4325**.

Appendix A

Form Approved
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Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Make a copy of this page and take it to the employer who offers coverage to help you answer these questions.

EMPLOYEE INFORMATION

1. Employee name (First, Middle, Last)	2. Employee Social Security Number
	___ – ___ – ____

EMPLOYER INFORMATION

3. Employer name	4. Employer Identification Number (EIN)
	__ – _____
5. Employer address	6. Employer phone number
	(___) ___ – ____
7. City	8. State / 9. ZIP code
	__ / _____

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
(___) ___ – ____	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

◯ **YES (Continue)** ◯ **NO (Stop here, and return to Step 4 in the application.)**

a. **If you're in a waiting or probationary period, when can you enroll in coverage?** (mm/dd/yyyy)

__ / __ / ____

List the names of anyone else who is eligible for coverage from this job.

Name	Name	Name

Tell us about the lowest-cost health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ..... ◯ Yes ◯ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

16. For the lowest-cost plan that meets the minimum value standard* offered **to the employee and family members requesting an exemption** (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.

a. How much would the employee have to pay in premiums for this plan? **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

17. What change, if any, will the employer make for the new plan year?

◯ Employer won't offer health coverage.

◯ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$**

b. How often? ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Once a month ◯ Quarterly ◯ Yearly

c. Date of change: (mm/dd/yyyy) __ / __ / ____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986). Most health plans offered by employers meet the minimum value standard.

Appendix C

Form Approved
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Assistance with completing this application

For certified application counselors, navigators, agents, and brokers only

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
   ☐☐/☐☐/☐☐☐☐

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change or remove your authorized representative, contact the Marketplace. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
   ☐☐☐ ☐☐☐-☐☐☐☐

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Signature of PERSON 1 listed on this application

11. Date signed (mm/dd/yyyy)
☐☐/☐☐/☐☐☐☐